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The Future of HIV Prevention, Health and Human Rights in Gay, other MSM and Transgender Communities: Towards More Effective Approaches with ICTs in a Web 2.0 World
Kaiser Family Foundation
July 26, 2012

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CHRISTOPHER WALSH: Welcome to the session today. The title of today's session is The Future of HIV Prevention, Health and Human Rights in Gay, other MSM and Transgender Communities: Towards More Effective Approaches in a Web 2.0 World. Some of the members that are gonna speak today were part of the HIVe, which is an online, open access resource community for communities disproportionally at risk of HIV and AIDS, and they've published some of their articles at www.hiv-e.org.

Feel free to visit the website to have a look at their articles after the presentation. Also, some of the speakers have provided a number of handouts, the handouts are up here in the front. At the end of the presentation or if you want during the presentation you might want to grab some of the handouts from the different presenters. Currently we're missing one of our presenters, he's not here yet, but hopefully he will arrive as we begin.

To start off I just wanted to set the scene and sort of the reason why we're here today, kind of with this session about the future of HIV prevention. Right now we're in the fourth decade of the global AIDS epidemic and digital technologies have solidified themselves as a new setting for HIV and AIDS risk, prevention, and also community response.

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The internet and social networking platforms, they've transformed into personal relationships, interactions, and it's making it much easier than ever for individuals to find new sexual partners. Of course this is particularly true among gay men, other MSM, and transgenders. We have many geo social technologies like Grinder, Hornet, etcetera, where you can find sexual partners within a number of meters to where you are. This is raising new questions in terms of how we can provide HIV prevention messages, as well as care and education.

I think the members of the panel were quite perplexed to as why prevention as a solution is not a more concurrently considered in the drive to build a global consensus around eradicating HIV. The digitally mediated, structural drivers of HIV remain sort of marginalized by a medical and behavioral change research and education models for HIV and then AIDS interventions.

But we know that digital technologies have undoubtedly increased the possibility through high risk sexual behaviors, but at the same time and unfortunately as I think that these presentations will show, there are equally powerful tools for sexual health and community mobilization, yet simply deploying these technologies for HIV prevention does not eliminate the vulnerabilities and lack of access to sexual, legal, and health

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rights, and education that put gay men, MSM, and transgenders at personal risk of HIV in the first place.

Improving the access to health and human rights for marginalized gay men, other MSM, and transgender populations, while it's an important policy goal of HIV prevention and educational practices, it remains a key research in implementation design challenge for global and public health. In addition the profound changes brought about by these digital technologies on sexual practices they also hamper the effectiveness of biomedical HIV, AIDS research, prevention and care.

We saw yesterday in the session in regenerating HIV prevention, Brian Rosen [misspelled?] talked quite eloquently about the fact that even with antiretroviral medications there hasn't necessarily been a decline in the number of new HIV incidence among high risk communities. It becomes really important to think what is the impact of digital technologies on this as well.

I think the papers in this unique symposium, they're gonna provide community-based examples of innovative developments using ICTs that have greater potential to impact upon HIV prevention in care, health and human right outcomes. I really do want to stress that they're community-based examples, they're not broad scale examples. They're community

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based, they're contextualized, and they're particularly important for the communities that they serve.

Without further ado I want to introduce the next speaker, who is Nada Chaiyajit.

NADA CHAIYAJIT: Hi. Good afternoon, everyone. My name is Nada Chaiyajit from Bridges Across Borders South East Asia Community Legal Education Initiative or you can [inaudible].

Before my presentation I would love to ask you that. I couldn't believe that -- have you ever known anything about Thai transgender before or have you ever been to Thailand before? Okay, you might be surprised that we are on almost every corner of the street, but it doesn't mean we are accepted, so by this presentation I would love to give you some background about why we have to run this program called [inaudible], sustaining grassroots access to HIV prevention, rights and justice with ICTs, but I provide my [inaudible].

I would like to provide a background [inaudible] online counseling service, because in Thailand transgender sex, extreme human rights abuses, and gender [inaudible]. It look like invisible, because as I mentioned before that we are survive in the society, but it doesn't mean that we are accepted, because Thailand is completely [inaudible] to society.

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Additionally the prevalence among transgender is higher than gay men and all the MSM occurring to the UNAIDS, so we enter 2010 then, so just 50-percent of transgender woman use condom with their partner. And of course transgender look at me that we are not gay, and order MSM, that's why we need specifically program to meet our needs on sexual health and human rights.

[Inaudible] Sexperts! is an online counseling service that was assigned to provide a safe space for our friends, transgenders, individuals to share our lives experiences, and talk about important issues that related to our way of life, like beauty, gender sexual assignments, and how to finding boyfriends, and how to getting a job, or how to access to our education that we need. [inaudible] Sexperts! is unique, because we use a low cost community based example that integrates HIV prevention and human rights, education within the peer based counseling service that decide to empower transgender to be proud about who we are.

How about who we are? Okay, because we are transgender, as we know, and we are [inaudible] about transgender sex, both pre and post operation, we know how to talk about [inaudible], we know how to talk about safe sex and pressures for all transgender, very welcome to ask any questions about sex and pressure for that lifestyle. We know

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how to talk about access to justice. We know how to refer transgender to sexual health services, excess logistics through university based critical education [inaudible], and we know how to talk, how to empower them to feel proud about who they are.

How to make them feel very good about them self, about their bodies. So we started program, by received training from [inaudible] successful program called, We are a Sexpert [misspelled?]. With their technical support with our [inaudible] University Kingdom, and through the funded 2010 until 2011.

We are [inaudible] counseling, because we use completely social networking, because we are a [inaudible] community-based group, and we are transgender helping our community to combat stigma, discrimination, and we try to help our friend access to human rights and overcome abuses.

By using tree path forum [misspelled?] through the digital world, we used our web board, we can access to see [inaudible] and yes, our beloved friends Facebook, [inaudible] Sexperts, and also our friends who need a private counseling, just log into the MSN Instant Message [inaudible] sexpert@hotmail.com.

How we work, [inaudible] we starting just only two Thai transgender groups on Facebook. Now from the start just have

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about 400 members, but from about nine months our member raising from 400 to 1,019 members, and so we connect with [inaudible] human rights groups that almost the place for [inaudible] activists to join, share information about a movement.

On the Facebook we do disseminate information about sexual pressure, safe sex, personal risk to HIV, legal, human rights through the web board and through the Facebook Safe Sexperts [misspelled?]. We use these all three Facebook sites to advertise our service. Our peer counselor will provide that, hey guys or girls, we are now available for chats.

About any issue that's important for transgender life in Thailand just come to talk to us, and we usually starting chat about gender reassignment, because we know exactly what our friend needs. So we starting to provide a context about beauty tips, home and use, surgeries, how to find boyfriends, how to communicate with them, even you want to have sexual pressure with them, how to find information.

Of course we get a lot of information, we heard a lot about sexual harassment and human rights violations among them, so we help them find out what they could release the problems. Within these chats [inaudible] information about safe sex, personal risk to HIV and other STIs, of course we help them to accept this justice, and because if they need any help.

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During that we educate them to learn about their rights, their rights under Thai constitutions, let them know that they have rights, and we are here, because we want them to know that. You have friends, you are not alone.

For some clients and from some friends that need private chats as I mentioned, MSN Messenger and Facebook chats is available from Monday to Friday from 8:30 to 11:30 p.m. Of course if you have any questions that you want to know you can post on our web board at any times. And these we working through the computers, but now we can see that life changes a lot in Thailand, because almost all our friends can access internet through the mobile devices, so we can use smart phone or tablets to provide information.

This is a chat at how we work. We have a home based called [inaudible] that's where we create a content that related very interesting for transgender needs, and then we provide the content through the Facebooks, and advertise the contents [inaudible] and human rights activists Facebook. After that we try to communicate with them and invite them to a private counseling through the MSN and their Facebook chats.

This is our Facebook page, [inaudible] Sexperts! page. I should state photos to show you that we are willing to speak a lot about derise [misspelled?], because we know that our friends always face our stigma and discrimination in the

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society. This is the way we advertise. This is our web board. This is MSN instant message. [Inaudible], because of limited uptime that I made a copy, I mentioned earlier, I made about 40 copies of handouts that put on this stage, and because of [inaudible] about how we work, especially about example chats, just feel free to get it.

This is the outcome that how we sexpertise [misspelled?] our society now, we're friend. I can say that our program is effective, because since September 2011 we have had over 300 chats already. Our approach is low cost, we use just only social networking effectively, and our approach is very unique and very proudly, because we build the trust, and empowering them to [inaudible] transgender in a community.

Also our approach is effective, because we integrate sexual health and human rights education together, [inaudible] online counseling service. Our approach specifically to support transgender to understand about personal reach to HIV and empowering them at the same time. Thank you for [inaudible] [applause].

CHRISTOPHER WALSH: Thank you, Nada. Our next presenter is going to be Mehdi Karkouri, and he's from Morocco, and he's gonna be talking about using ICT solutions to reach MSM in Morocco.

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MEHDI KARKOUI: Thank you very much. Hi, everybody. My name is Mehdi Karkouri. I come from Morocco, I work in a community-based organization named ISAS, which stands for [inaudible], which is working in the field of HIV and AIDS for more than 20 years. I'm pleased to share with you today our little experience in using ICT solution to reach MSM in Morocco.

In Morocco we have low overall HIV prevalence, but the HIV prevalence has been found to be highly disproportionate among MSM with no surprise. Some BBSS [misspelled?] studies have shown that it could be as high as 5.5-percent among MSM with comparison to 0.1 in the general population. The legal context is unfavorable, almost [inaudible] as in many Islamic and African country illegal in Morocco. Homophobia, high level of stigma, violence, gay bashing, police harassment are the common social drivers of risk in Morocco.

And on the other hand development and diffusion of ICT in Morocco has lead to a switch from gay and MSM people no more go to cruising areas, they just set up dates on internet, so that's why we thought that it would be useful to have presence on the internet.

Just to give you an idea, our MSM program which started in 1993 is a traditional prevention program, with condom and lube access information, work on self esteem improvement, and

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we have also some psycho social support and income generating activities, but our coverage is limited to major urban centers.

What is our intervention on internet? We go to the most popular gay site in Morocco and we create a profile which we name Pleasure and Health, something neutral, but also explicit at the same time. We sent a standard message to users explaining why we are there and what we can offer, and we invite them for further personal chat, so persons who are interested they can switch to instant messaging on MSN when they can have individual conversation with the provider, and the conversations are recorded for us.

We have a kind of database where we collect all the frequently asked questions, and we have a standard response, so we can answer very quick, as you may know on the internet things go very, very fast, so that we just copy and paste for the FAQ. We go on gay sites. The services we provide, education and information about HIV and STIs. We have some tailored counseling sessions, this has safer sex practice.

We can also do differences to our HIV testing and counseling sites, which are MSN friendly. We promote our HIV outline, so if people have more question. We give information on our program and more important we offer a safe space to talk about homosexuality in a very unfavorable context.

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At the same time we just started a new initiative which is baking up the internet prevention. We have partnered with OneWorld UK to create a SMS platform, it just started last year. At the same time we also have a talk show on the radio which is airing weekly for two hours. We have a sexologist who can answer questions from young people, it's on a very popular young radio station and people can make telephone calls or send emails, or ask on the Facebook page. This is the Facebook page, and this is the SMS platform webpage.

What are the results? I'm sorry we have very few, because it's a very new program, a little program who has just started. We don't have so much data, but we have just basic information, because we can see that the number of next context from one semester to another. We also have pretty good rate of follow up context, people who can keep chatting with us and as you may see, we have around 20-percent of people who decline the invitation.

What are the most popular topics that people ask for? Prevention, of course, sexual practices, and safer sex practices, stigma and discrimination, people also ask questions about religions, and issues of religion and homosexuality, family and society, and also about living with HIV. The most important reference we make is for our hotline, but also for our HIV testing and counseling sites.

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People are also referred to our website which contains some educational material. As we just started a MSM health clinic in one city which is, Marrakesh. People calling or who are located in Marrakesh are referred to this health clinic for service provision.

What are the lessons learned? We saw that we have a very high accessibility from internet people. We estimate that the rate of decline is low, about 20-percent. It's very low cost of operations, you just need an internet connection, which is very cheap. You need of course a provider. It's safe.

This kind of intervention ensures safety, both for the users, but also for the providers, because our outreach prevention programs people go to cruising areas where they may experience some police harassment or gay bashing actions. We offer a safe space to talk about sexual practices, people are encouraged to talk about their homosexuality, which they may not be able to do with physical encounter.

It's an opportunity to scale up our services, because we can reach people or MSN who are not located only in the major urban cities. So it's an opportunity to reach people we cannot reach physically. Also we have this referral services which are more effective.

What is the way forward? Now we need to have a formal evaluation of this program, it's program which started as I say

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very little, and now we want to evaluate it. We want also to know what is the impact of this program on the change of behaviors, of the users, so that we can be able to scale up the service provision. Also we feel that we need more research to handle the potential of ICT solution for targeting MSM in a context like ours. Thank you very much [applause].

CHRISTOPHER WALSH: Thank you, Mehdi. Our next speaker is Leo Schenk, and he's from Poz & Proud in the Netherlands. The title of his presentation is Bringing Sexy Back into Community Empowerment: The Poz & Proud Experience with Social Networks in the Netherlands.

LEO SCHENK: Thank you, Chris. Before I start I'd like to thank firsts of all a couple people whom without I would not be standing here. The organizing committee for inviting me, Chris Amugicks [misspelled?] for mentoring and supporting me through this process. The brave man of Poz & Proud of course stood up when it mattered most, and last but certainly not least, Andrea, my husband, without his love and support I wouldn't be standing here. This one's for your Andrea.

This session is on the future, but I'd like to take you back to the past a little bit first. I came to Amsterdam in 1990 and I started working as a professional HIV prevention worker for the Schorer Foundation, the Schorer Foundation is a

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national gay and lesbian health organization, which went bankrupt earlier this year by the way.

In that time gay men were still dying of AIDS. There was a lot of solidarity within our community, and there was no internet, there was no Grindr, no GayRomeo, and mannered to meet in parks, in bars and clubs to meet, to socialize or have sex. Safe sex was still the norm at that time, and unprotected sex, even talking about it was still a great taboo.

The majority of the gay men in Amsterdam and in the Netherlands were not tested, because HIV testing was discouraged at the time. And bare backing, the term to describe unprotected sex had yet to be invented. That all changed dramatically, of course in 1996 with the arrival of the effective HIV treatment, which gave new perspective to lives of people living with HIV and also gay men living with HIV. There was a growing number of sexual active gay men in the scene living in relative health and being sexual active as well. The internet expanded our possibilities and our ways of communicating.

The solidarity in the gay scene of the 80s and the 90s had vanished like snow for the sun. Gay men were no longer seen as victims, but seen as offenders, and were held accountable for the spreading of HIV. In media reports and in white society, gay men living with HIV was set aside as hyper

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sexual and irresponsible beings, and this all resulted in gay men living with HIV, not daring to disclose their status to friends and sex partners.

What hadn't changed for the stigma and [inaudible] and it even gotten worse in that time. On a professional level I noticed that my organizations and professional HIV fields lost site of a very great amount of gay men, especially gay men living with HIV, whose needs weren't met in that time.

Now anger is almost never a good motivation to produce something in life once you establish something, but I can assure you that as an activist, anger is the number one motivation to get things done, and I was angry. I was angry at the gay scene for the lack of support from our community. I was angry at the lack of self-esteem [inaudible] gay men living with HIV.

I was angry at the professional field also, they didn't meet our needs and were actually feeding on the negative perceptions in the media reports of gay men living with HIV. And I was angry at myself for not standing up. I became a volunteer for the Dutch HIV Association, and I wrote an article in its gay magazine calling up on gay men living with HIV to gather and form a group to make sure our needs were met. In April 26, 2006, a group of positive men came together and formed Poz & Proud.

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Poz & Proud is part of the Dutch HIV Association. It's run entirely by volunteers. It has a gold group of six members and 20 more volunteers who help organize with our activities. We get a yearly budget of the HIV Association of 12,000 euro to get our things done and to organize activities.

Poz & Proud is a digitally driven community process, structural HIV prevention, and sexual health promotion, by confronting three stubborn sources of stigma, self stigma, stigma in a community, and stigma in the community, and stigma in the media and the wider society.

A key platform of us became enhancing sexual rights of positive men. These rights have been ignored for several years and shelved under the carpets. In a climate of fear, standing up for your sexual rights as a gay man living with HIV was very confrontational at that time. In the first couple years of our existence we met a lot of resistance, not only by the public health professionals and the media, but also from gay men living with HIV themselves who found our in your face approach not productive for the imaging of gay men living with HIV in our community.

Poz & Proud model is if we don't do it no one else will, and we have three main activities. The first one is providing information on sexual health and political matters, advocacy to ensure the needs of gay men living with HIV are met

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by the HIV professionals, and organizing social activities and support.

We use social networking to address several issues, to overcome time and distance barriers, to direct gay men living with HIV to honest information, sexual health and political matters, and to provide access to relevant and meaningful opinions, and online support. Now we started our digital experience with an online forum in 2006. The forum was on sexual health and rights for HIV positive gay men.

Now this online forum showed us that there was a need of gay men living with HIV to discuss these personal and political matters in s a safe space. The forum inspired us to start a blog in 2007 was this. Gay men having access to informational sexual health, and sexual practices written by people like them in a language they could understand, and without judgment.

We started several series on the blog. One is named the P of Proud, where gay men living with HIV wrote about their time of diagnosis, and how they handled and tackled stigma and self stigma. All the positive men contributed regularly on these posts and shared their experience and point of view on these matters.

Now we linked these online contributions to real time events, such as our information events on Hepatitis C, or our

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information lines on anal health, and made gay men living with HIV aware of the sexual health matters. I will say we make them awake.

By the end of 2009 we started our Facebook group where we integrated our social activities by using social networking. We started out with six members and at first it was difficult to get men interested to join the group, most of them had problems with the public character of the group. Family and friends might see if they were becoming a member of this group and most of them were ashamed to do that, but over time the number of men that joined our group grew, grew, and now we have over 220 members, and they share views, and experiences, and support.

Now being together openly and showing membership in our Facebook group have been key in overcoming isolation, to channel stigma, and really finally with HIV as a digitally networked social practice, rather than something that had to be managed alone.

We tackle also stigma in our community. Every year we organize test and tell, that's our community action to channel stigma in the community. With our test and tell action we encourage gay men to get tested for HIV and to get tested for STIs regularly, and to disclose their HIV status to each other, not only because knowledge is power, but also because we want

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to make HIV more visible in the scene. With this community action we became to speak prevention activists.

Now we shifted from viewing, living with HIV as an individual challenge to addressing the political and social, cultural environment that affected our lives, and tackled stigma in a median society as a whole through advocacy.

One example of these is yearly, the results of [inaudible] are presented. The [inaudible] is an online survey among gay men about their sexual practice. It's a quantitative research and it showed for instance that 70-percent of the gay men living with HIV had unprotected sex. Now without this, the richer context of why these men had unprotected sex and with whom these men had unprotected sex, the negative perception of gay men living with HIV in a media gay community, siding among HIV professionals were contributed to the stigmatized sexual active gay men living with HIV. We became more empowered and developed the research attitude of [inaudible].

Together with the Dutch HIV Association and the Amsterdam Health Municipal, we set out a community based research by gathering an online participant group of 212 gay men living with HIV. We learned from a survey that gay men living with HIV use various risk reduction strategies to avoid transmitting HIV to their sexual partners, such as serosorting or viral sorting.

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This research was a key turning point in our advocacy towards changing how public health authorities perceived gay men living with HIV. This research was a key in overcoming, was a key turning point in our efficacy in changing how our public health authorities perceived gay men.

Together we had social networking and gay men living with HIV to charter our own lives in media, public health and society without stigma in a meaningful stigma-fighting framework. Our rep is up, I have no time left, but now I'm closing my presentation.

Our members realized what was a truly challenging stigma about more than attending workshop empowerment when initial [inaudible] away and people go home to their daily lives. What works was a sustained connection with a social network where internet plays a crucial role. The digital approaches apply together with the social activities, add value by continuously mobilizing social capital to make difference. Not only to feel and experience stigma, attitudes and self-esteem, but also overall, health outcomes. Thank you. [Applause].

CHRISTOPHER WALSH: Thank you, Leo, and we have another presentation now from Franz Mananga and its online HIV prevention with MSM communities in African contexts, lessons from Cameroon.

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FRANZ MANANGA: Thank you. Good afternoon, everybody. I'm Franz Mananga as he said. I come from Cameroon, [inaudible] Organization which is called Alternative Cameroon. I will present you the use of the internet in male sexual encounters, by men who have sex with men in Cameroon.

First of all, I would like to present to you the general local context. In the last year, civil studies has highlighted both the risk faced men who have sex with men in sub-Saharan African countries in terms of exposure to HIV and AIDS and higher HIV prevalence among them when compared with other HIV transmission categories.

In Cameroon, where our studies took place, general data of 5.4-percent prevalence in indigenous populations makes very large disparities on MSM are confronted with an increased risk of HIV infection. The growing visibility of this previously invisible concentrated epidemic has not been accompanied by change in terms of nations.

Response to the HIV/AIDS epidemic. Moreover, during the last year, the two last year, while UNAIDS and the Global Fund made the respect of human rights and sexuality a priority, many African countries have seen [inaudible] of and application evolve to the [inaudible] of homosexual practices, banishing MSM underground and depriving them of access to prevention and care. The Cameroon context is marred by many things and social

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and antisocial and political rejection and repression of homosexuality.

Study and objectives. That's an observation from the field. Internet is a major war in disclosure, communication and encounters between MSMs are made possible but refuse to this [inaudible] discretion in sub-Saharan countries, depriving field of potentially of age in terms of adapting prevention, strategy and intervention.

The objectives of our study was to define the proportion and profile of patients having recourse to the internet to meet men sexual partner in order to implement targeted prevention messages in these MSM populations.

The mental delusion. This too is based on that on both on a quantitative survey and an intervention. Quantitative that have from a survey on the sexual activity and practices of MSM carried out by a local association which is called [inaudible] Cameroon where I come from with the support of the French association which is called Aide between May and June 2008 in Douala in a convenient sample of 168 MSM.

The criteria for inclusion in the study where has followed being a man, age at least 18 years, resident in Douala for at least 6 months and having had at least one sexual encounter with another man during the course of his life. For this studying, the outcome of interest was having made sexual

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partners over the internet and a logistical regression was commuted on the 153 participants who answered the questions on the meeting place of male sexual partners.

We also collected quantitative data from the online prevention intervention carried out by Alternative Cameroon. The Alternative analysis of activity reports and interviews carried with Alternative Cameroon members and they enable a more in-depth analysis of the quantitative data.

The result. 34-percent of respondent indicated having made their partner off the internet. This was the seven more frequent means of meeting partners after meeting true friends. In the [inaudible] analysis, having university education level, not having a lucrative activity and having had a larger number of partners during the course of the previous six month where independence correlates of having made sexual partner on the internet.

Always the results. During 2010, that's from the online prevention intervention have shown that the sites most visited by MSM in Cameroon were [French] in French, in [French] also in French. 37 internet chats were ousted over the year. 307 contacts were made during these interventions. The perception of risk of exposures to an infection with HIV and AIDS was not widespread in person encountered in the internet based intervention.

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The knowledge about mode of transmissions was limited and many had erroneous ideas on personal risk to HIV infection. This was much more frequently the case for those underground and the time is used to describe people who had their sexuality with men or who are not contact with MSM or the homosexual network in Douala.

Numerous cases of blackmail and violence were documented. The fear of being exposed to different form of violence linked to frequenting the internet and to sharing their identity, orientation and/or sexual practices to no other one was a recurrence object for discussion. Consequently, the Association Alternative Cameroon made great difficulty in trying to assure the follow up of this internet prevention based interventions and it was more difficult to continue to exchange [inaudible] in charge of an interpersonal exchange.

Discussion. This result are among the first to focus on the internet has anything placed for MSM and on the possibilities of implementing internet based prevention interventions in Cameroon and sub-Saharan African countries. They show that more than a third of those interviewed used meeting site on the internet to meet their sexual partners, which is consistent with a medium analysis by Lieu [French] in 2006, showing that in studies recording that MSM not through

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the internet, 40-percent reported using the medium to meet the sexual partner.

In 11 countries, studies showed that the internet plays an important role in the constitution and functioning of social and sexual networks. In contexts where same-sex security are punishable by law as in Cameroon, internet hosts appear have a favorite meeting place which requires greater understanding.

Limitation of the study. I will go quickly. Firstly, confidence simply was the only way to assuring the safety of the participant and what's advantageous in the mobilization of the participant, but may have into those selection years. Our study was carried out in a limited [inaudible] and economic center of Douala's size, studies probably offers a greater degree of sexual liberty and greater opportunities to meet male sexual partner. Access to the views of the internet is also much greater than in other region in city Cameroon.

The conclusion. Our result clearly shows the necessity to implement internet based prevention intentions while developing [inaudible] and parallel complimentary research in order to better understand the views of the internet of MSM, but in Cameroon and in other countries where a hostile environment compels a large number of MSM to go underground, the intervention has transitioned need to be conceptualized and the implantation of the internet base intervention should also

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be accompanied by the implementation of processes system and evolution in order to rapidly made practices available to better prevention. Thank you. [Applause].

CHRISTOPHER WALSH: Thank you, Franz. I'm just going to summarize a little bit and then open up for questions and discussion. There's a number of microphones around the room.

The reason we have the participants from diverse contexts here is to share what they're doing because it's real-time and it's also future oriented and next generation critical and also social approaches that leverage digital technologies and they provide new conceptual frameworks and models. They're not just interventions, but I think they're innovations. They're HIV prevention and care innovations that have the potential to be sustainable as we've seen through some of the talks that we've just heard

What's important about them is that each of the case studies, and they're quite diverse, but they all draw on and they valorize the agency and legitimate experience and the emotional and the practical knowledge of gay men, MSM, or hidden MSM and transgendered communities. That's very important.

It also leverages the potential and value added network, digital technologies for strategic knowledge sharing and collaborative learning, across communities and

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organizations which is really quite essential and a lot of it is guided by evidence base. It's also guided by expertise and resources that are sometimes limited and hard to provide, to particularly underground communities where they have to risk criminalization or jail just for being homosexual, and they're also quite low cost.

All of the examples are very low cost and what's also quite interesting about these examples is that they disrupt biomedical and some of the normative community development, HIV research and educational practices that we're being told we must roll out through the kinds of programs that are available and through the kinds of funding that are available.

It hypothesizes an alternative theory to the dominant approach of treatment as prevention. Basically, I think what's important about these is that they endorse that HIV prevention is still a solution in the epidemic four decades in. I want to thank the participants for sharing all of their innovations and their interventions and then we'd like to open up for any questions that you would like to ask any of the participants. So thank you.

ALEX CABALLO-DIEGUEZ: Hi. I'm Alex Caballo-Dieguez from Columbia University in New York City. Several of your presentations have highlighted how important the internet connections and networking are in environments where

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homosexuality is forbidden or there's a lot of stigma. I was wondering if there were any instances of entrapment whether there are governmental agencies or the police or whatever that are using the networks to try to entrap people and extort money or any kind of action that is oppressive.

CHRISTOPHER WALSH: It doesn't look like any of the participants would have an answer to that question. I think in the research, particularly in Africa, there has been some cases of this happening. If anyone from the panel can say something from their particular communities that they work with where that's happened, but I think with the ideas of confidentiality, because this is research, usually the users are being very confidential with who they're talking to and they're quite confidential with the data that they collect and they are using anonymous sites and anonymous names and remaining anonymous.

ALEX CABALLO-DIEGUEZ: No, I understand that within the context of research anonymity is a preserve, but there were discussions about how the presence of this networks allowed people who before would be socializing in bars and public places to connect over the internet. I'm sure that in the Netherlands that's not a problem, but I wonder whether in Thailand or in Africa, this could be grounds that people could be exposing themselves to risk.

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NADA CHAYAJIT: As I understood, I like to share some idea to kind of give some answers to you. For my case in Thailand, for the people who have access to the internet, is far, far, far away from access to information for preserve their health, sexual health and justice. Like for example, cares in Chiang Mai, where my office is located, we work closely to the M-Plus Foundation, they have MSM and TG community based organization.

They do outreach. They provide outreach work through the communities to the sex worker, for example, they face this kind of political issue through the local government sector, but because it's really difficult for them to provide lube and condom for instance to give to their other friends like sex worker or MSM and TG, that we found in one case interesting that police tried to stop and said the way you work is very, it's turned the society worse than before. The more you provide condoms, the more you provide spread HIV around the cities and something like this, but we work closely to the community so they get information about how to protect themselves really clearly.

But think about people who just sit in front of the computer or just access to through the internet [inaudible] all the time that you may see a lot in Thailand in my country that everyone is just looking at the phone, even not talking to each

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other. They are isolated to access this kind of face-to-face information, but why we are here is because we want to make sure that we stand for them, that whatever they need, they just tag it on facebook.

On behalf, I'm manager for [inaudible] expert, every time that my friend tags me, that I know exactly, so if a while ago, if my peer counselor a while ago just come to answer them and one interesting case as we found and can help them is not about police.

It's about young transgender who just in the sophomore years, she has to become a good teacher, that she's become an intern teachers to the school and the security board of the school just accept and the first one and later on, the security board said, hey we have to issue this letter to say, hey, we have to reject you because just being transgender is worse than being a good role model for our student.

By these cases, we cannot just wait, okay? So refer to the clinical beds so we use our network based on our [inaudible] to connect them likely to national human right commissions support immediately, so the problem fixed us in one week. So our friends can go teaching another [inaudible] school to be a good role model, one of the good role model for the society.

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MARCO GOMES: My name is March Gomes. I'm from Toronto, Canada. Now I don't want to make this a story about me, but I'm positive for close to ten years. At the beginning of when I became positive, a year into it, I became very involved in the community. I did a film and all of that stuff and my number one goal was to make sure that young people living with HIV or not living with HIV were aware that living with HIV and even though we're in a generation where there is treatment and it will keep us alive, that it will not, it is not the main thing that we should focus on.

I am tired, that's why I've gotten out of this entire field, I'm tired of speaking to my friends and speaking to just normal young people and them thinking, that because I've got HIV and that my viral load is suppressed, that I'm okay. They don't understand the complications and the effects that go into HIV on a normal basis, physical and mental.

So my question is to people on the panel, even though you are doing what you can to make sure that MSM or effected populations most at risk are able to understand prevention strategies or treatment strategies, what is it that your countries or your programs are doing to make sure that it reaches even those people that are not most at risk because let's face it, we're living in a world, if you're poor, you're

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rich, what you are, you're affected by HIV and you are also at risk. That is my belief.

What is it that you are doing to make sure that we reach those people? That young people are aware that just having a treatment is not the answer to living a well-satisfied life with HIV.

LEO SCHENK: Thank you for your question. I hear this a lot from gay men living with HIV in the Netherlands as well. My point of view on this issue is that we see a lot of gay men like you get a lot of gay men like other people. There's no one certain gay man living with HIV. There are several types, and one has more problems to deal with than the other one.

I might say it as well. I think that health professionals and also gay men living with HIV or gay men as such think that it's okay for youngsters to do risky sexual activates because they feel that there is a medication and that it's okay, and that HIV is not a big think anymore, and I get different signals from every guy we see that turns positive, it's still a big blow in his life and it's still affects him a lot.

Sure, now when I got HIV, it was a time when there were medications, people had to deal with it coming over this diagnosis a lot longer than now. The younger generation is now much more capable of coping with it, but I'm not sure that

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young people think that HIV is not a big deal anymore. I think that's an urban myth or so in the professional field. We had a lot as well about professionalism in the Netherlands, whenever there's a rise in HIV, [inaudible] okay, this is because the younger generation of gay men doesn't feel it's HIV is a threat anymore.

Well, I work in the field, I see a lot of young men turn positive and I can assure you that they don't feel lightly about it.

CHRISTOPHER WALSH: I also think that generally education is a problem and there is a lack of education directed at young people, in the media for example and we believe in prevention as a solution, the members on this panel, and what we're saying is that these are small examples of communities taking it upon themselves because what's happened is they've been ignored by broader political movements and particularly by people in the medical field.

There obviously needs to be some better discourse between people in the biomedical field and community based activists and researchers and educators who are on the frontlines and dealing with some of the things that Leo just mentioned.

One of the things that we've been doing, that many of the members of the board have worked together to make the

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interventions available in an open access journal to help other community-based organizations tell their stories so that more successful interventions can be shared, the idea that prevention is still really a possibility and if we're really ongoing to turn the tide together, as the name of this conference, then there has to be more cross-dialogue between biomedical prevention activists, if they are activist, and biomedical and people who support biomedical approaches and the people in social sciences because we know prevention is possible.

It's worked in the past, but something's gone wrong, so I think these panelists have shown that small community-based solutions, they work and that if more people get involved and taking care of their communities, and there are many affected communities that are not hit by some of these movements, but the ideas that we need to rethink prevention across the board, that's what I would say. Any other questions?

MALE SPEAKER: I'll try and be quick. You mentioned an online journal, so many you could tell me the name of that. Also, you mentioned doing work in South Africa. I'm a researcher and I'm interested in doing online work. I was wondering, were you able to trace the movement of people in the internet successfully and then finally, you spoke about

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evaluations, I was wondering what type of evaluation tools were you hoping to use to assess your program?

MEHDI KARKOURI: Sorry, I didn't get that.

MALE SPEAKER: The gentleman talked about evaluating this tool, and he said that was one of the last things that his action steps were, so I was wondering what type of evaluations had you considered and then I was wondering on sub-Saharan, how had you tracked movement or did you track movement of people a lot?

MEHDI KARKOURI: Thank you. Actually, the very mission is the next step. We haven't taken the evaluation and as I mentioned in the beginning, this is a very new program for us, which has begun very little, very small and no, just we had those, we saw the shift in the MSM population, people were going more into internet.

We also feel that0020even we try to scale up our prevention, our convention of prevention program, we are not reaching everybody so we just said, okay, let's just try this internet prevention way, and see what happens, see if we have positive signs, we'll think about how to formalize the program and how to scale up.

That's why even the data I have are very poor, you know, just the number of contacts, the number of people declining, so now we are thinking about having formal

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evaluation, asking for help from the international expertise to see how we can build and shape a real prevention program on the internet.

CHRISTOPHER WALSH: One question you asked was about the journal. It's www.hiv-e.org and there's ten pieces there and what happened was that mentors worked with community based activists and frontline workers to have them tell their stories and to have them write up their interventions in to a peer reviewed journal articles and then the ten pieces were then published in a journal called Digital Culture and Education and it has a powerful introduction by Judith Auerbach.

It talks about some of the strategies that different organizations and NGOs have used and there's case studies from India, from Thailand, from Cameroon, from the U.S. and so I think that answers that question. Do you have one more question?

MALE SPEAKER: Were you able to track the movement of your population in Africa using the internet? Did you see movement from city to city or country to country? And were you successfully able to do that with your intervention? And what was the name of the journal site again one more time?

CHRISTOPHER WALSH: Digital Culture and Education. That was a question for Franz, right? About tracking, yes.

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FRANZ MANANGA: Sorry, I didn't understand your question. Sorry, could you speak slowly because I'm not fluent in English, okay?

MALE SPEAKER: Were you able to track movement of the MSM population using the internet from city to city or country to country?

FRANZ MANANGA: From city to city.

MICHAEL CAVNAUGH: Hi, I'm Michael Cavnaugh, I run a website called www.hivhero.org for newly diagnosed people living with HIV and one of our big goals is trying to promote preventions, especially in young people in America and particularly in New York City. There's still a big problem because young people are still thinking they're invisible and having unprotected sex.

One of the things we've found or what I've been trying to do is producing different videos that are connected for example, we do a Broadway Hero of the Month video, so we interview a Broadway star. Those kinds of interviews have been brining lots of traffic and what we do in those videos is we include information and a message about being tested and being safe.

Another thing we've done very successfully is leverage celebrities or any kind of people like that by doing a reel of people saying condoms are hot, everything from Angela Lansbury

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to Bebe Neuwirth to all the stars that are around on the red carpets, so my question is, what do you think is the best way to reach young people and people that aren't going to necessarily going to go to GMAC in America to find information about HIV?

LEO SCHENK: I'd like to answer that. I think in my experience, because I was an HIV prevention worker in the past and also an activist for Poz and Proud, what basically it needs that you listen to the young people, find some activists in the group itself, because it's so easy for, I don't know if you're a professional organization or also a volunteer organization.

MICHAEL CAVNAUGH: We're a 501-3 pending organization. So we've been around three years.

LEO SCHENK: What I know in the Netherlands is that the professional HIV field lost their sight of that the needs of gay men and also younger gay men were and if you don't look at those problems or those groups in terms of listening to them, going to them and finding out what they want to hear about and how they want to be reached and how they want to be informed, I think that's more important what we as professionals want to do with those groups.

CHRISTOPHER WALSH: I also think contextual behavioral research is a good idea. In Thailand, we worked with a group

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call M-Plus and we know that the sexual practices in Thailand are quite different from city to city.

And so we did a behavioral research where we interviewed a large number of MSM transgender and some hidden MSM community members to find out what their sexual practices were because sexuality there is so fluid, no one really identifies as gay and they don't use these terms, basically what we did when we analyzed that behavioral research, there were trends and then one of the things that we did particularly to hit younger populations, we designed animations that told stories that helped them understand personal risk to HIV rather than the mantra of use condoms and lube, use condoms and lube.

They were stories that were immediately recognizable to the people in the community about personal risk to HIV and particularly, one was made for sex workers, one was made for young MSM that had to do with drug use, one was made for hidden MSM and also the women who have co-habitate with them and then another was made for transgenders because what happened with the transgender population for example, young transgenders is that men were wanting to have sex with them and not use a condom because they couldn't get pregnant, so this whole notion was there.

The animations are available on YouTube and then popular opinion leaders or peer outreach workers would use them

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at hotspots and then also use them in the peer outreach because we know the people are using digital technologies and they're not going to organizations, but they might be going to Grinder, they might be going to ManHunt or Planet Romeo or these other places and if there is information available, then perhaps they might seek some of that information.

Planet Romeo is in some ways at least we heard with the MSM pre-conference that they have teamed up in Germany to provide a really robust form of HIV prevention methods on that platform there, but it's specific to Germany. So I think that's a good model to possibly look at.

BJORG SANDKJAER: Hi, my name is Bjorg Sandkjaer. I work for NORAD, the Norwegian Development Agency. I'd like to thank all the presenters for very interesting presentations. I was particularly interested in the two experiences from the two African countries, so my questions will go to the two of you.

Working very difficult contexts of criminalization, both of you had found some of your informers on cruising sites. It would be interesting to hear from you what the reaction was from the people on the site to you being there and also to providing counseling through that kind of medium.

Related to that, it could be interesting to hear more from you on how you build trust. There was a question earlier about have you experienced or are there other people on those

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sites who use it as an opportunity to access MSM in these contexts. I noticed in the presentation from Cameroon, you mentioned that there have been some incidences of blackmail. It would be interesting if you could unpack that a bit more so that we could understand more about how you could use this very useful tool to work in those contexts. Thank you.

MEHDI KARKOURI: Thank you for your question. When we first started our internet activities, people were very happy actually with this new form of prevention and we had a lot of encouragement of people on the net saying that's good what we are doing, but I have to say that we have not started from scratch because my organization exists from 25 years and we have started prevention for MSM since 1993.

In our context, is little completely, it's kind of schizophrenic, because you know in Morocco homosexuality is illegal, but the law rarely enforced. Just for example, when the elections are soon, so politicians ask police to do some gay arrests to say, look, we are doing our job, but in the meantime, it's kind of liberal.

For example, from the Ministry of Health, MSM are one of the targeted, top priority population and if you go to the Ministry of Health and look at their documents, you can read that they are working with MSM and they acknowledge the presence of MSM in Morocco, but if you go to the next building

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across the street in the Ministry of Justice or in the police department, you won't find such documents, so we can work on the field.

We have also an agreement, an oral agreement with the police when we go to the cruising areas on site, sometimes there are some police arrests and police say that our activist, when they do arrest on the field, if you say I am from the AIDS, I am doing prevention, they say, okay, we won't arrest you.

So we managed to work, but of course we also have this repressive load and we also have to tread that it could be enforced more effectively. One day, especially now with the Arab spring, which turned to be maybe an Arab fall, because we have new elections and we have Islamic government, so we are still wondering what will be the position of the government if they still allow us to work so freely with those populations on that.

FRANZ MANANGA: For your question, I can tell you that we can't do anything about the people who are blackmailing a lot of people on email. The only thing that we have to do because we are in Douala, the city of Douala and our center is called Access Centre, it's very African frequented by the MSM community in Douala and in Cameroon because we are an AIDS center and we do also prevention and care.

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Because we are peer educator, when working or doing online activates and when peer educator knows that there are some people who are blackmailing those people in the community and inside the community, we just make the list of those people and the list with the pseudonyms of those people because you know, on internet, you don't give your real name and what we doing, we just put the list in front our Access Centre, and all people who coming in our center, we just tell them that you have to be very careful because there are some people who are blackmailing or doing extortion violence.

Also our peer educator when they are doing their activity, their online activities, there's also a way among the people that they prevent online activities. You have to be careful because this pseudonym is very dangerous. He's blackmailing other people inside the community in Cameroon. You have to be very careful. That's the only way, the only control we have to prevent those cases.

BARRY DAYTON: My name is Barry Dayton. I'm from Palm Springs, California, from the Desert AIDS Project and the population that we serve, the client population that we serve is largely MSM. I was familiar with some of the programs that were trying to take alternative approaches in this day of Grinder and all the other ways of hooking up and so forth.

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I understand what's been said, I think, about are we really turning the tide if there continues to be these great transmission rates among MSM? We certainly see that in our service area because we have an average HIV infection rate, and we test at about 25 locations throughout our area, of about 3-percent on average, compared to 1-percent for the national average, so I'm very interested in this.

I know this is an organic process getting to what works because what works in my backyard may not work in yours. I applaud everything that I've heard at this conference about really having community leaders lead the efforts in their own communities rather than just saying, well, the government's got this or I heard about this AIDS free generation, so it's done.

I don't really have a question as such other than to say we are in the process of putting together a comprehensive testing project that we think will ultimately become multi-year and has a variety of different target populations. Latinos, people of color, women, seniors, etcetera and of course one of those is MSM as well, so what I want to say is I would like to share my card with any or all of you and please just keep me appraised of what you find out.

CHRISTOPHER WALSH: One of the things that we have done is that all of the presenters have provided handouts at the front with contact information and also more information about

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their organizations because all of the presenters are not from English-speaking countries and the idea was to give a global snapshot to a point of community based organizations taking it upon themselves to try to turn the tide in their own context and their contextual interventions and innovations.

BARRY DAYTON: This is kind of cumulative follow up based on the session that I saw yesterday as well. Thank you.

JUDY ANN: Hi, Judy Ann from the New York City Health and Hospitals Corporation. I have a question and that's directed to the speakers from Thailand and Morocco. The first question is regarding the training for the counselors or the peer educators. What kind of training was provided for them? What kind of training was provided for them? And the second question is regarding the referrals, the health services, were there any follow ups on that to determine the effectiveness of it and how is that done since I'm assuming a lot of these encounters were anonymous?

NADA CHAIYAJIT: I will take pains to answer what kind of training I and my colleagues receive. We can in three training, three as we receive training about we are the sex workers from [inaudible] in Stockholm, Sweden, that the training is teach us about how we can understand the message, the message from our friends because the message is really important to learn how our friends feel or how the concern or

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the problem that they have been facing through their daily life related to transgender issues or MSM issues.

What we have to do is about to check it and to create it, a message to answer creatively, make it sexy, make it more interesting, not just hey, stop using lotion or lubrication because it may cause the condom breakage; must have something before that to let them feel that the way they want to be or want to feel, the sexual pressure is very good, support them to feel that they are good to the way they are because example for Thai transgenders, we are always heard that being transgendered is like a curse or something from the previous life. First to clear the stage, we have to let them know that to being yourself is very okay. This is the main incentive we would train, that we are the sex worker from RSF house.

The second is about then we know how to provide or to create a message through our clients, but we want to know specifically more about legal and human rights if there are issues. That's why my organizations afford medical or legal experts on how to train people.

The more there is cause, CCLE, Criminal Community Legal Education, using the America method to train people how to speak or how to refer the case on using their active method, like online resources or together with the AMFAR funded through the program, that we create the human rights and sexual rights

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made known, specifically for MSM and transgender and also sex worker. Then even our peer counselor receive the questions about human rights legal issue, they just go and open it through the online or human aids, print it out as a hardcopy to use it.

The third training is we call sex gender and sexually programs that we receive from the local or foundations. They are willing to work for our health support because they believe that HIV and AIDS problem is not just about only sexual interaction, but it's about social structure that are present for a long, long time before we realize the problem, we have to learn how to understand where is our position in the society.

CHRISTOPHER WALSH: Any referrals you have to BCCT or other organizations?

NADA CHAIYAJIT: From this service as sex workers around about 30. It's not much to referral, it's about 10-percent from the chats because even we are just nine months, but it's a long way to build a trust for the transgender people to release the fear and come for a health checkups and things. Yes.

MEHDI KARKOURI: We have basically the providers, the counselors, they are peer educators. The providers are basically peer educators and we have a curriculum for peer educators.

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We just add some training about communication skills, but we already had some feedback from our providers that it's maybe a way different and that we have to think about a designated training because on internet, it goes very fast. It's difficult to draw attention of people that are there. It's a different context then the traditional people education work.

So yes, one of the things we are thinking about with the scale of the program is to design a training, dedicated training. Referral is one of the weak points and we acknowledge that we have to work on that, so until now, when we refer people to our other services, HIV testing, counseling or to the men health clinics, they just ask them to self-identify themselves that they are coming from, that they get the information on internet, but we are fully aware that not everyone will say that, so this is what we plan to add in the next program.

CHRISTOPHER WALSH: I'm afraid that we've come to the end of the session. It's not 6PM. So if anyone else has a question, if you could maybe ask it to the individual session participant at the end. I just wanted to give everyone a round of applause and thank you so much. [Applause].

[END RECORDING]

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